Registry Form – Pediatric

IDENTIFYING INFORMATION:

Child's First Name:_____Middle:_____Last:_____

English spoken? ☐Yes ☐No

English understood? ☐Yes ☐No

Primary Language:_____

Date of Birth:

Sex:

Street Address:_____Apt #:_____

_____

City:_____State:____Zip Code:_____

Phone #:_____

Phone #:_____

Phone #:_____

Primary Caregiver:

Name: _____Relationship to child:_____

Phone #:_____

Primary Language:_____

Literacy Level:_____

Independent with child's care? ☐Yes ☐No

Is it okay to release information to this person? ☐Yes ☐No

Alternate Caregiver #1:

Name: _____Relationship to child:_____

Phone #:_____

Primary Language:_____

Literacy Level:_____

Independent with child's care? ☐Yes ☐No

Is it okay to release information to this person? ☐Yes ☐No

Alternate Caregiver #2:

Name: _____Relationship to child:_____

Phone #:_____

Primary Language:_____

Literacy Level:_____

Independent with child's care? ☐Yes ☐No

Is it okay to release information to this person? ☐Yes ☐No

Emergency Contact:

Name: _____Relationship to child:_____

Phone #:_____

Primary Language:_____

Literacy Level:_____

Independent with child's care? ☐Yes ☐No

Is it okay to release information to this person? ☐Yes ☐No

Out of Town Emergency Contact:
Name: _____Relationship to child:_____
Phone #:_____
Primary Language:_____
Literacy Level:_____

Independent with child's care? ☐Yes ☐No

Is it okay to release information to this person? ☐Yes ☐No

Pets: ☐No ☐Yes If yes, describe pets: (names, types, and weights): _____
_____

RESIDENCE:

Type of home: ☐Single family home ☐Mobile home ☐Apartment

☐Other: _____

EVACUATION PLANNING:
Family Transportation

☐Private car ☐Bus ☐None ☐Other:_____
Can you transport your child by yourself?
Can your child be transported in a car?
If yes, who will drive the car?
If no, what other requirements does your child have?

☐Ambulance
Name of Ambulance company:_____
Contact name:_____
Phone #:_____

☐Wheelchair Van
Owned by:_____
Contact name:_____
Phone #:_____

☐Other:_____
Evacuation plan:_____

Do you and your child live in a designated "surge" or "flood" zone? ☐Yes ☐No

Does your neighborhood flood often? ☐Yes ☐No

Is your home in a mandatory evacuation zone? ☐Yes ☐No
How many caregivers/family members would need to be evacuated with you?_____

SHELTER PLANNING:
What is your plan for shelter if you don't evacuate?_____

What is your plan for shelter if you do evacuate?_____

Are your child's caregivers independent with the care of your child?

How many caregivers are involved in directly caring for your child?

Would your child require medical personnel assistance?

Would your child require electricity to continue care?

CARE: Emergency Care Level:_____

Diagnosis(es): _____

Allergies: (medications, foods to be avoided and why)

_____

_____

Immunizations:											
Dates						**Dates**					
DPT						**Hep B**					
OPV						**Varicella**					
MMR						**TB status**					
HIB						**Other**					

Are the child's immunizations entered into the state registry? ☐Yes ☐No ☐Unknown

Functional Limitations:

☐Blind/sight impaired ☐Deaf/hearing impaired ☐Mental disability

☐Memory impaired ☐Heart/cardiac problems ☐Breathing/respiratory problems

☐Transplant ☐Cancer ☐Paralysis

☐HIV/AIDS ☐Recent surgery

☐Diabetic

☐Insulin dependent (shots)

☐Oral medicine (pills only)

☐Diet management only

☐Other:_____

☐Other:_____

Does your child have an Advance Directive or Do Not Resuscitate order? ☐Yes ☐No

If yes, describe:_____

TREATMENTS/EQUIPMENT:

Medications: ☐See Medication List ☐None

_____

Equipment: ☐See equipment list/Title XIX ☐None

☐Ventilator/Respirator

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Generator? ☐Yes ☐No Fuel:_____Last Tested:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐Oxygen

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment/tanks:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐Pulse Oximeter

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐Infusion/IV pump

Name/type of medications administered by IV:_____

_____

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐Enteral pump

Type of formula/enteral feeding:_____

Amount:_____Frequency:_____Duration:_____

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Can the child tolerate bolus or gravity feedings temporarily? ☐Yes ☐No

Does the caregiver know how to give bolus or gravity feedings independently? ☐Yes ☐No

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐Apnea Monitor

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐Phototherapy lights

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐CPAP/BIPAP machine

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐Nebulizer

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

☐Other:_____

Name/type of machine:_____

Internal battery life:_____hours/minutes

Electricity needed to maintain? ☐Yes ☐No

Back up equipment:_____

Equipment settings:_____

Usage orders:_____

Managing physician:_____Phone #:_____

Name of provider:_____Phone #:_____

Ambulation capacity:

☐Confined to bed

☐Wheelchair

Type:_____

Provided by:_____Phone #:_____

☐Walker ☐None ☐Other:_____

Supplies: ☐See supply list/Title XIX ☐None

_____

_____

Name of provider:_____Phone #:_____

Other: ☐See medical information ☐None

☐Trach

Type:_____

Size:_____

Site care:_____

Patient/ Caregiver independent with site care? ☐Yes ☐No

☐Feeding tube

Type:_____

Size:_____

Site care:_____

Patient/ Caregiver independent with site care? ☐Yes ☐No

Patient/ Caregiver independent with feedings? ☐Yes ☐No

☐Urinary catheter

Type:_____ Frequency:_____

Size:_____

Site care:_____

Patient/ Caregiver independent with catheterization? ☐Yes ☐No

☐ IV Access

☐Central line/PICC ☐Port ☐Peripheral ☐Other:_____

Date placed:_____External length:_____

Site care:_____

Caregiver independent with site care? ☐Yes ☐No

☐Other:_____

_____

_____

Nearest hospital:_____

Hospital preference:_____

Insurance information:_____

School Nurse: Name:_____School:_____

Social Worker:

Name:_____

Name:_____

State

Equipment Vendor: Name:_____

Supply Vendor: Name:_____

PDN Company: Name:_____

Other Providers:

Name:_____

Name:_____

Name:_____

Doctor(s):

Name:_____

Name:_____

Name:_____

EMERGENCY PHONE #s:

What home health services does your child receive and from whom?

☐Home Health Nurse Name:_____Phone #:_____

☐Private Duty Nurse Name:_____Phone #:_____

☐Home Health Therapy Name:_____Phone #:_____

☐Pharmacy Name:_____Phone #:_____

☐Home Equipment Name:_____Phone #:_____

☐Medical Supplies Name:_____Phone #:_____

Primary Care Physician Name:_____Phone #:_____

Physician: Name:_____Specialty:_____Phone #:_____

Physician: Name:_____Specialty:_____Phone #:_____

Physician: Name:_____Specialty:_____Phone #:_____

Physician: Name:_____Specialty:_____Phone #:_____

Physician: Name:_____Specialty:_____Phone #:_____

School Nurse: Name:_____School:_____Phone #:_____

Fire Station: Name:_____Phone #:_____

Police Station: Name:_____Phone #:_____

Poison Control Center: Phone #:_____

Electric Company: Name:_____Phone #:_____

Telephone Company: Name:_____Phone #:_____

Gas Company: Name:_____Phone #:_____